STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING _____ B. WING _____	C 08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SPRINGS HEALTH CAMPUS	**2400 SILHAVY ROAD VALPARAISO, IN 46383**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00132541, IN00132978, and IN00134933.

This visit was in conjunction with a Post Survey Revisit (PSR) to a Recertification and State Licensure Survey completed on 07/02/13. This visit included the PSR to the investigations of Complaints IN00128508, IN00128614, IN00128738, and IN00130059.

Complaint IN00132541 substantiated, no deficiencies related to the allegation are cited.

Complaint IN00132978 substantiated, no deficiencies related to the allegation are cited.

Complaint IN00134933 substantiated, no deficiencies related to the allegation are cited.

Survey dates: August 26, 27, and 28, 2013

Facility number: 012766
Provider number: 155795
AIM number: 201051640

Survey team:
Regina Sanders, RN, TC
Heather Hite, RN (August 26 and 27, 2013)
Caitlyn Doyle, RN
Jennifer Redlin, RN

Census bed type:
SNF: 39
SNF/NF: 19
Residential: 55
Total: 113

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING _____ B. WING _____	C 08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SPRINGS HEALTH CAMPUS	**2400 SILHAVY ROAD VALPARAISO, IN 46383**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Census Payor type: Medicare: 34 Medicaid: 10 Other: 69 Total: 113 Sample: 8 Avalon Springs Health Campus was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the investigation of Complaints IN00132541, IN00132978, and IN00134933. Quality review completed on September 2, 2013, by Janelyn Kulik, RN.	F 000		